California Tobacco Control Update 2009

20 Years Of Tobacco Control In California

California Department Of Public Health, California Tobacco Control Program

Arnold Schwarzenegger, Governor
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California Department of Public Health, California Tobacco Control Program. 2009. *California Tobacco Control Update 2009: 20 Years of Tobacco Control in California*: Sacramento, CA.

Forward

Twenty years ago, on November 8, 1988, California voters ushered in what would become one of the world's most successful public health programs. The Tobacco Tax and Health Protection Act (Proposition 99) implemented a 25 cent tax on each pack of cigarettes sold in California and created the Tobacco Control Section (now known as the California Tobacco Control Program [CTCP]). This report is the fifth in a series of updates, detailing the strategies, challenges and successes of CTCP. The first California Tobacco Control Update (August 2000) established statewide measures and described trends in tobacco-related attitudes, behaviors, policies and activities. The second (2002) and third (2004) Updates reported on trends, data and policies from which progress in tobacco control could be assessed. The fourth Update (2006) highlighted progress in tobacco control using the framework of logic models developed for evaluating comprehensive tobacco control programs by the Centers for Disease Control and Prevention (CDC). This report also provided background information on California's tobacco control environment, described the social norm change strategies used by CTCP, and presented trends for long-term outcomes as a reflection of California tobacco control efforts. This fifth Update (2008) revisits California's tobacco control environment as the program nears its 20th anniversary and addresses the need for strategies to continue working toward the Tobacco Education and Research Oversight Committee (TEROC) goals of reducing adult smoking prevalence in California to less than 10 percent and reducing youth smoking prevalence to less than eight percent by 2008.* This report also describes California's social norm change strategies with the support of updated evidence and presents updated trends for long-term outcomes as an indication of California's current tobacco control success.

*Based on combined California Adult Tobacco Survey/Behavioral Risk Factor Surveillance System (BRFSS) data, the 2007 California adult smoking prevalence rate was 13.8 percent. Based on the California Student Tobacco Survey, a nationally comparable school-based survey, the 2006 California high school smoking prevalence rate was 15.4 percent.

Introduction

Since its inception 20 years ago, the California Department of Public Health (CDPH), California Tobacco Control Program (CTCP) has been responsible for decreasing tobacco-related diseases and deaths in California by reducing tobacco use across the state. The landmark 1988 California Tobacco Tax and Health Promotion Act (Proposition [Prop] 99) enabled California to become the first state to implement a comprehensive tobacco control program and begin working toward this goal. CTCP is an international public health model that has saved lives and transformed society by reducing adult smoking prevalence by 35 percent, from 22.7 percent in 1988 to 13.8 percent in 2007.* Additionally, from the start of the program, per capita cigarette consumption declined by 60.8 percent.† The program's ultimate goal of reducing deaths caused by smoking has also positively impacted the rates of lung and bronchus cancers which have declined almost four times faster than the rate of decline in the rest of the United States.‡ California has a long history as a national and international leader in tobacco control but the success of the program is slipping. As we reach the 20th anniversary of the establishment of California's tobacco control program, it is important to re-frame the needs and successes of the program and determine ways to re-establish California's status as a public health leader.

CTCP administers and coordinates the tobacco control efforts of 61 local health departments, hundreds of trained and experienced public health workers, thousands of adult and youth volunteers, approximately 40 community-based organizations, a statewide media campaign, a tobacco cessation helpline, and statewide technical support services. CTCP's comprehensive nature and its subsequent strength result from the combined efforts of its partners: non-governmental organizations, local tobacco control efforts, the University of California's Tobacco Related Disease Research Program (TRDRP) and the California Department of Education's (CDE) Tobacco Use Prevention Education (TUPE) program.

Twenty years after the inception of CTCP, the per capita budget for tobacco control in California is $2.19 which is well below the $12.12 per capita recommended by CDC for funding an effective statewide tobacco control program in California. CDC's 2007 Best Practices for Tobacco Control recommends an annual investment of $441.9 million for the state of California, while the entire CTCP and CDE budget for 2007 was $79.9 million.[1]

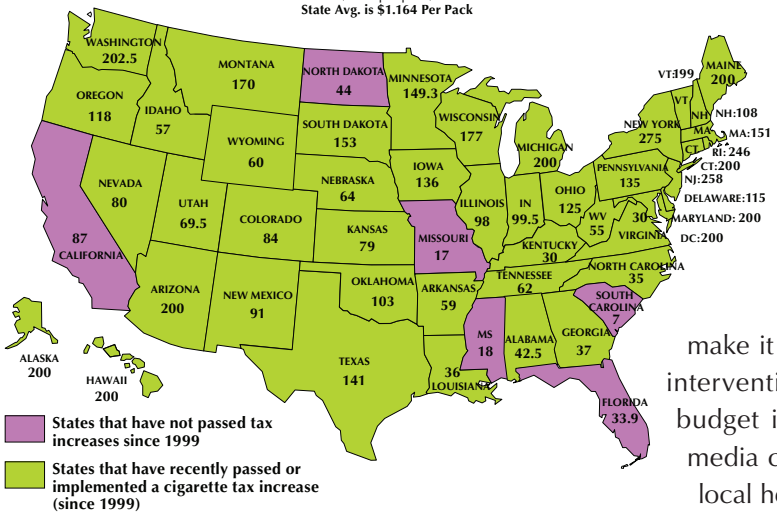
Additionally, the 30-day smoking prevalence among California high school students increased from 13.2 percent in 2004 to 15.4 percent in 2006.§ Moreover, the state of California has not increased its tobacco tax in 10 years and is one of only six states without a tobacco tax increase since 1999 (California, Florida,

* Behavioral Risk Factor Surveillance System 1984-1992, and California Adult Tobacco Survey combined data for 1993-2007.
† California State Board of Equalization (packs sold) and California Department of Finance (population). U.S Census, Tax Burden on Tobacco, and the United States Department of Agriculture.
‡ Rates are per 100,000 and age-adjusted to the 2000 U.S. standard (19 age groups).
§ The 2004 and 2006 data is from the California Student Tobacco Survey (CSTS). The 2004 data collection used active parental consent while the 2006 used a mixed parental consent procedure.

Figure 1. Cigarette Tax Rates

(cents per pack)

State Avg. is $1.164 Per Pack



DC's increase to $2.00 per pack effective on 10/1/2008; HI's increase to $2.00 per pack effective 9/30/2008; VT's increase to $1.99 per pack effective on 7/1/2008. Source: Tobacco Free Kids, June, 2008

Figure 2. CTCP Budget: 1989-1990 to 2008-2009

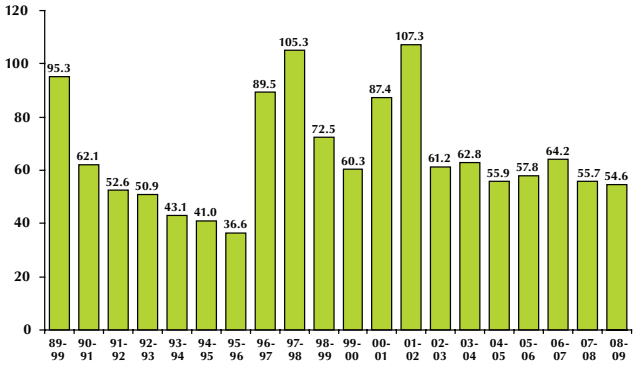
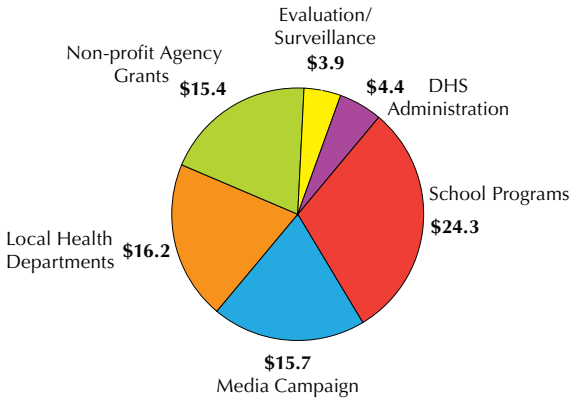


Figure 3. Tobacco Control Program Budget 2007/2008 (in millions)



Mississippi, Missouri, North Dakota, and South Carolina) (Figure 1). The average price of a pack of cigarettes is approximately four dollars, and the real price has decreased by 71 cents since 2003,[2] which may be contributing to the increasing smoking prevalence in youth and adults.[3]

Limited resources for tobacco control efforts in a state as large as California make it imperative to focus on population-level interventions (Figure 2). As a result, the CTCP budget is primarily dedicated to funding mass media campaigns, tobacco control initiatives by local health departments, and competitive grants for community-based organizations (Figure 3). Furthermore, grass-roots efforts continue to build momentum for statewide policies; such as the groundbreaking ban on smoking in restaurants and bars, effective January 1, 1995 and January 1, 1998, respectively,* followed by smoke-free tot lots and playgrounds legislation effective January 1, 2002.†

CTCP has continued to strive for success in the face of declining funding. The California program continues to pioneer efforts to eliminate secondhand smoke (SHS) in more public places, including the 2008 smoke-free cars law and continual emerging efforts on the local level to address smoke-free multi-unit housing (MUH), tobacco sampling, tobacco-free pharmacies, and Indian gaming casinos. In January 2008, CTCP also established the Capacity Building Network to address the needs of the tobacco control community and all CTCP-funded agencies working with priority populations, increase local capacity to effectively work with ethnically diverse populations, and increase the number of individuals with cultural sensitivity and experience in working with priority populations. Also in July 2008, major motion picture studios partnered with the state of California to include anti-tobacco advertisements (ads) developed by CTCP on DVDs rated G, PG and PG-13 that depicted/showed smoking, and this current agreement will run through 2009.

* California State Labor Code Section 6404.5.
† California Health and Safety Code Section 104495

The Paradigm: Social Norm Change

The foundation of the social norm change model holds that "the thoughts, values, morals and actions of individuals are tempered by their community" and that "durable social norm change occurs through shifts in the social environment of local communities, at the grass roots level" (Figure 4).[4]

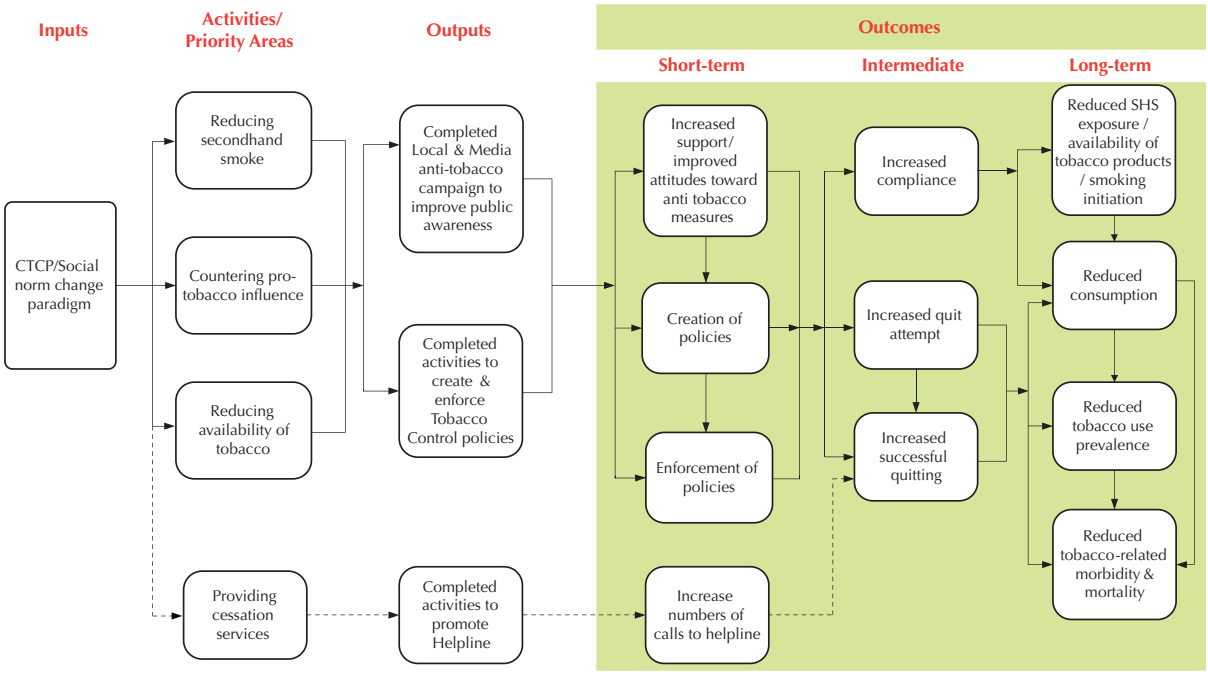
The primary intervention goal of CTCP is to change the broad social norms surrounding tobacco use by "indirectly influencing current and potential future tobacco users by creating a social milieu and legal climate in which tobacco becomes less desirable, less acceptable, and less accessible."[4]

Employing the social norm change model, CTCP focuses its tobacco control activities on four priority areas:

(1) Countering pro-tobacco influences in the community: working to curb the advertisement and marketing of tobacco products in the retail environment, through tobacco industry (TI) sponsorship of local events, and the depiction of tobacco products in the entertainment industry.
(2) Reducing exposure to secondhand smoke: promoting initiatives that use a policy and advocacy approach to restricting smoking in public and private places (emerging areas include policies associated with Indian casinos, MUH, and outdoor venues).

The goal of the California Tobacco Control Program is to change the broad social norms around the use of tobacco by "indirectly influencing current and potential future tobacco users by creating a social milieu and legal climate in which tobacco becomes less desirable, less acceptable, and less accessible." [4]

Figure 4. California Tobacco Control Program/Social Norm Change Paradigm As a Logic Model



Adapted from *Key Outcome Indicators for Evaluating Comprehensive Tobacco Control Programs.* Centers for Disease Control and Prevention, 2005

In 2005, the tobacco industry spent 22 times more money on tobacco advertising in California than CTCP spent on its entire program.

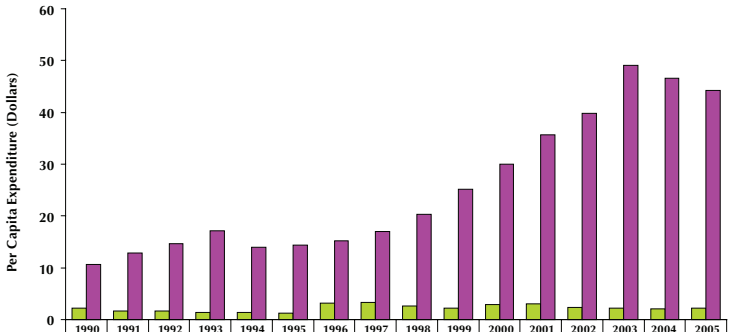
(3) Reducing the availability of tobacco: supporting the enforcement of existing laws that prohibit selling tobacco to minors, eliminating free tobacco product sampling, requiring licensure of tobacco retailers, and establishing tobacco-free pharmacies.

(4) Supporting services that help smokers quit: CTCP provides support for the operation of the California Smokers' Helpline and for community-based cessation programs.

Countering Pro-Tobacco Influences

As it has for 20 years, the California Tobacco Control Program's (CTCP) continued efforts to reduce and eliminate tobacco use and SHS exposure occur in the context of the well-funded and ever-shifting market tactics of the Tobacco Industry. Following the Master Settlement Agreement (MSA) in 1998,* the TI has continued to fervently market and promote its tobacco products in California and across the nation. TI advertising and promotional spending has always dwarfed CTCP funding and the disparity continues to grow. In the early years of CTCP, TI expenditures for advertising were five times the CTCP budget; and in 2005, the industry outspent CTCP by a ratio of 22 to 1 ($44.22 v. $2.24) (Figure 5). In 2005, the TI spent $843.8 million on marketing expenditures in the state of California alone ($13.36 billion nation-wide) which is a 67.3 percent increase from 1998 when TI marketing was restricted by the MSA between the states and the tobacco companies.[5]

Figure 5. Per Capita Tobacco Industry and Tobacco Control Expenditures in California, 1990-2005*



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Tobacco Control	$2.15	$1.73	$1.68	$1.44	$1.41	$1.20	$3.15	$3.38	$2.59	$2.25	$2.97	$3.01	$2.32	$2.27	$2.09	$2.24
Tobacco Industry	$10.70	$12.82	$14.65	$17.18	$13.94	$14.35	$15.23	$17.06	$20.37	$25.18	$29.97	$35.66	$39.86	$49.07	$46.61	$44.22

* California tobacco industry expenditures calculated as a proportion of U.S. expenditures based on total population size as reported by the U.S. Census Bureau. Both tobacco control and tobacco industry expenditures have been standardized to the U.S. 2005 dollar, based on the Consumer Price Index (CPI). Tobacco control expenditures are a combination of media campaign, competitive grant, local lead agencies (LLA), tobacco settlement fund, and California Department of Education HEA totals. Tobacco industry expenditures taken from the Federal Trade Commission Cigarette Report for 2005, issued 2007.

CTCP counters tobacco industry influences through the Tobacco Education Media Campaign, by monitoring event sponsorship to detect potential MSA violations, and by initiating local policy action.

The TI continues to increase its efforts to influence California politics through campaign contributions to legislators, legislative candidates, political parties and constitutional officers.[6] The TI also continues to aggressively promote and market tobacco products to specific target populations, which has led to continued addiction among vulnerable members of California's communities.

CTCP exposes and counters TI influences through the Tobacco Education Media Campaign, by monitoring TI event sponsorship to detect potential MSA marketing and advertising violations, and by initiating local policy action to restrict tobacco sales and retail advertising and marketing practices.

* The Master Settlement Agreement (MSA) in 1998 resolved claims by 46 states against six major U.S. cigarette manufacturers accused of marketing to minors and misleading the public about the safety of their products. Master Settlement Agreement. Office of the Attorney General, State of California, Accessed 9/29/2008. Available at: http://ag.ca.gov/tobacco/msa.php

The Tobacco Education Media Campaign

During the fiscal year 2007-2008, the media campaign operated on a $15.7 million budget. The media campaign was designed to be a population-wide mass-media intervention with the intention of increasing public awareness surrounding the TI's deceptive marketing and public relation tactics in California. By doing so, it counteracts the success of industry practices.[7] The campaign uses paid commercials and public service announcements, incorporating several media components such as television, radio, billboards, print, and public relations activities. These campaign activities raise the consciousness of Californians, thereby increasing negative attitudes toward the TI and supporting the creation of policies that discourage the distribution of free tobacco products and industry sponsorship. California's media campaign focuses its attention on the general market, but also targets some specific racial/ethnic priority populations through television, radio and print media using strong counter-tobacco industry and secondhand smoke messaging.

According to the findings from the Tobacco Education Media Campaign, negative industry attitudes and beliefs are strongly correlated with a greater number of quit attempts and future quit intentions.

The media campaign has been primarily responsible for affecting attitudes and beliefs, based on the premise that a change in attitudes often precedes a behavior change, such as individual smoking behavior. Generally, the program's anti-TI television advertisements (ads) aim to deglamorize smoking, expose the manipulative tactics of the TI, and direct any resulting anger back at the TI.

A person's beliefs regarding TI practices along with attitudes toward the industry combine to form an individual's perceptions about the TI. For example, the anti-TI television ad "Icons" presents glamorous images used by the TI with the intention of exposing how the industry manipulates people into thinking that smoking is attractive. However, the ad ends with a more accurate depiction of the repercussions of smoking: a seriously ill man in a wheelchair who warns that the reality of the situation is that the viewer could "end up like this." There is evidence that awareness of this specific ad resulted in a more negative attitude towards the tobacco industry six months after the ad was launched.* Negative industry attitudes and beliefs have been shown to be strongly correlated with a greater number of quit attempts and with future quit intentions.*

Smoking in the movies has become an increasingly visible battleground in tobacco control. In May 2007, the Motion Picture Association of America (MPAA) started including smoking as a factor in the process of rating films.[8] Following the decision, Disney, Universal, and Hallmark released new policies for allowing smoking in their films. In July 2008, the state of California partnered with the Entertainment Industry Foundation (EIF) and six major motion picture studios to include anti-tobacco ads on DVDs of new movie releases which depict tobacco use and are rated G, PG and PG-13.[9] Under this agreement, the studios will use four anti-tobacco ads developed by the CTCP TEMC. The current agreement will run through 2009 and additional anti-tobacco ads may be included on DVDs in the future.

* Longitudinal analysis of California Media Evaluation surveys, 2005-2008 (not published).

Monitoring Tobacco Industry Marketing, Event Sponsorship and Retail Advertising

California systematically and consistently tracks TI event sponsorship and retail advertising to better understand TI tactics and trends, and is the only state to do so. The California Tobacco Assessment Study (CTAS), the Tobacco Industry Event Monitoring Project, and Project SMART $ (Sponsorship Mission: Avoid Reliance on Tobacco) monitor and document TI marketing, promotions, and sponsorship of California events for violations of the MSA and relevant state laws.

Since the signing of the MSA, the retail outlet has become the most important communication channel between the tobacco companies and current and future smokers. This venue has the potential to reach more consumers than other venues because it exposes all shoppers, regardless of age or smoking status, to pro-smoking messages that project powerful cues to smoke and stimulate cigarette purchases.[10, 11]

Although tobacco advertising, promotions, and marketing in the retail environment are largely unregulated, California has limited bidi sales and self-service displays of tobacco products to adult only venues,* requires licensure of retailers who sell tobacco by the California Board of Equalization,† and requires the posting of Stop Tobacco Access to Kids Enforcement (STAKE) Act age-of-sale warning signs around checkout registers stating that tobacco sales are limited to those who are 18 and older.‡

The CTAS is a longitudinal prospective cohort study with questions designed to document the extent of cigarette and smokeless tobacco marketing materials and prices of selected brands within California stores that sell tobacco. Between 2000 and 2008, standardized observations of tobacco-related marketing materials in retail outlets were made at six time points (2000, annually from 2002 to 2005, and 2008). In 2008 approximately half of cigarette signs advertised a sales promotion and almost three-quarters of retail outlets had at least one sign with a cigarette sales promotion, which, coupled with decreases in the prices of three major cigarette brands, causes concern because of the association between lower prices and increased cigarette consumption. Compared to cigarette marketing in stores, smokeless tobacco marketing is relatively small and the decrease in marketing seen between 2005 and 2008 is encouraging. However, fewer than half of the stores (45.3 percent) posted a license that was visible to customers, which is required by law, and only 55 percent posted STAKE Act signage near the counter.[12]

The Tobacco Industry Event Monitoring Project is designed to identify the nature and extent of tobacco sponsorship and marketing, document the possible violations of marketing restrictions for action, and observe the sponsorship changes over years through public event observation in California. In 2006, approximately

* California Penal Code Section 308.1; California Business and Professions Code Section 22962
† California Business and Professions Code Section 22972, 22980.1
‡ California Business and Professions Code Section 22952(a)

60.3 percent of the observed events had tobacco sponsorship, with most sponsorship taking place during "non-arts" events. Of the 16 rodeo events, 8 bull riding events, 4 team roping events and 12 motor sport events (both auto racing and motorcycle racing), 44 percent, 73 percent, 100 percent and 80 percent, respectively, had TI sponsorship in 2006. Most of these were sponsored solely by United States Smokeless Tobacco (92.7 percent) or by co-sponsorship with other brands, while Skoal ranked as the second-highest brand seen at these events.

Project SMART $ is a workgroup that aims to eliminate TI sponsorship of and influence upon California's diverse events, venues and organizations. The goals of this project include: promoting the adoption of policies prohibiting TI sponsorship of local events, venues, or organizations; systematically collecting, analyzing and disseminating data related to TI sponsorship activity; and providing technical assistance and training to local projects and other appropriate organizations regarding current and future sponsorship issues. Project SMART $ has documented two significant outcomes: (1) the identification of potential TI marketing or business practice violations, and (2) the adoption of voluntary policies by organizations that might be susceptible to accepting TI funding. Additionally, in May of 2006, the collective efforts of Project SMART $ and the Attorney General's office led to a $5 million settlement with R.J. Reynolds to resolve a lawsuit over the firm's distribution of free cigarettes on public grounds.[13]

Initiating Local Policy Action

CTCP works to counter TI influence by encouraging and initiating local policy action to restrict tobacco sales, tobacco retail advertising, and TI marketing practices. The Strategic Tobacco Retail Effort (STORE) Campaign aims to mobilize collective action within individual communities by initiating local policy action to restrict tobacco sales and marketing practices. This intervention also attempts to facilitate better enforcement of local and state laws that focus on retail advertising and tobacco sales; from 2002–08, the STORE campaign has provided 36 trainings and has produced 143 different materials (tips and tools, fact sheets, guides, sample letters, etc.) related to tobacco retail advertising and sales.

Many local tobacco control program efforts and activities address the marketing tactics used by the TI to promote tobacco products and their use, and the public image of tobacco companies. These activities include: the adoption and/or implementation of policies that control the extent of tobacco advertising and promotions inside and outside the store; increasing the number of print media organizations (e.g. newspapers and magazines) with a voluntary policy that regulates tobacco advertising; increasing the proportion of communities with policies that regulate tobacco sponsorship at entertainment and sporting venues, county fairs, rodeos, motor sport events, parades, and concerts (or voluntary regulation by the venues themselves); and the promotion of voluntary policies prohibiting tobacco company contributions to groups and institutions such as education, research, public health, women's organizations, cultural and entertainment events, fraternity/sorority groups, and social service institutions.

Activities and policy adoption at the local level often lead to statewide policy adoption. For example, California has experienced a 200 percent increase in the number of retail licensing ordinances between 2000 and 2007. This push for retail licensing at the local level culminated in a statewide law in 1995 requiring businesses selling cigarettes and other tobacco products to the public to have a California Cigarette and Tobacco Products License.

Secondhand smoke (SHS) is a mixture of over 4,000 chemicals which contaminates indoor and outdoor air.[15] Exposure to SHS can lead to adverse health effects such as lung cancer, heart disease, and respiratory illnesses in non-smokers.

Many statewide efforts to counter TI influence succeed due to grassroots support at the local level. One-third of the risk of youth smoking initiation has been attributed to actors smoking in the movies.[14] Through funding from the CTCP. The California Youth Advocacy Network (CYAN) launched the "Tobacco and Hollywood" campaign in 2004, joining a national movement that has been active since the mid-1990s. The campaign raises public awareness about the issue of smoking in movies and organizes California communities and organizations to advocate for the responsible depiction of tobacco in movies. As a result of the campaign, California tobacco control advocates have secured over 30 endorsements from parents, political, health and school groups such as the California State Parent Teacher Association, and the California Medical Association Alliance, and over 5,000 petitions have been signed in support of the campaign.

Reducing Exposure To Secondhand Smoke

SHS is a mixture of over 4,000 chemicals which contaminates indoor and outdoor air.[15] Exposure to SHS can lead to adverse health effects such as lung cancer, heart disease, and respiratory illnesses in non-smokers. As a priority, CTCP works to reduce exposure to SHS by promoting initiatives that use a policy and advocacy approach to restricting smoking in public and private places and to monitor knowledge and attitudes about SHS exposure among Californians.

Promoting Policy and Advocacy

SHS policies protect non-smokers from exposure to tobacco smoke and promote quitting behavior by changing the social norm around smoking. To help protect the public's health, CTCP promotes initiatives that use a policy and advocacy approach to restrict smoking in public and private places.

California is a national and international pioneer regarding the adoption and implementation of policies to protect the public's health from exposure to SHS, and has achieved significant progress toward reducing SHS exposure. California was the first state to implement a smoke-free indoor workplace law in 1995. This statewide law banned smoking in most indoor workplaces, including restaurants and clubs. The smoke-free bar provision of this law went into effect in 1998.* The state of California continues to reduce exposure to SHS by promoting smoke-free policies for areas that were not covered by the smoke-free workplace law, such

* California State Labor Code Section 6404.5.

as beaches, entryways, playgrounds, college campuses, outdoor dining areas, multi-unit housing, and casinos. For example, in January 2004, a law prohibiting smoking within 20 feet of main entrances, exits, and operable windows of all public buildings went into effect.* Additionally, as of January 2008, there were 26 smoke-free beaches on the California coast[16] and 103 cities and counties in California with smoke-free park laws.[17] In January 2008, a state law prohibiting smoking in a moving or parked vehicle with any youth under 18 years of age went into effect.†

Currently CTCP and its constituents are working on expanding the smoke-free frontier to include protections in multi-unit housing (MUH). In California, approximately 11 million people (34 percent) live in MUH, the second most common type of residential unit after single family homes.‡ MUH structures with shared interior walls are typically subject to less outdoor airflow into the units compared to single-family detached houses. This can result in SHS becoming trapped inside individual units and moving from one adjacent unit to another.[18] Moreover, low socioeconomic status is often related to disparities in housing choices such as MUH. As of May, 2008, 16 California cities and counties had adopted local ordinances, resolutions, and/or housing authority policies related to drifting second-hand smoke in MUH.[19] CTCP continues to maintain its position as a leader while moving toward eliminating SHS exposure in MUH environments.

In January 2008, a law prohibiting smoking in a moving or parked vehicle with any youth under 18 years of age went into effect.

Monitoring Knowledge and Attitudes

It is important to continually monitor knowledge and attitudes regarding SHS exposure because knowledge (increased knowledge of the effects of SHS) and attitudes (stronger attitudes against the TI and/or aligned with anti-smoking issues) have been shown to influence behavior. Additionally, changes in knowledge and attitudes can lead to increased support for SHS policies and provide information regarding public opinion surrounding SHS policies.

Public opinion is overwhelmingly in support of SHS policies in California:

- In 2007, 93.1 percent of California diners preferred eating in smoke-free restaurants.§
- In 2007, an overwhelming majority of Californians agreed on SHS-related issues:[20]
    - 75.8 percent of Californians agreed that smoking should be prohibited in outdoor dining areas at restaurants (72.2 percent in 2006).
    - 66.5 percent of Californians preferred public beaches to be smoke-free (58.6 percent in 2006).
    - 72.8 percent of Californians agreed that smoking should not be allowed in Indian casinos (71.7 percent in 2006).

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* California State Government Code Section 7596-7598
† California Health and Safety Code Section 118947- 118949; California Vehicle Code Section 12814.6.
‡ United States Census Bureau, 2000.
§ California Adult Tobacco Survey (CATS), 2007, California Department of Public Health.

Additionally, according to the most recent California Student Tobacco Survey (CSTS) in 2006, the majority of youth in California (6-12th grade) are protected from SHS in households and in cars.* Although the majority of youth in California already report that they are not exposed to SHS, the law prohibiting smoking in cars with children under 18 (which went into effect in January, 2008) should lead to an even larger reduction in the number of youth exposed to SHS in cars. The impact of this law on SHS exposure to youth will be closely monitored in the future.

Between 1995 and 2007, the illegal sales rate decreased from 37 percent to 10.7 percent, however, it increased to 12.6 percent in 2008

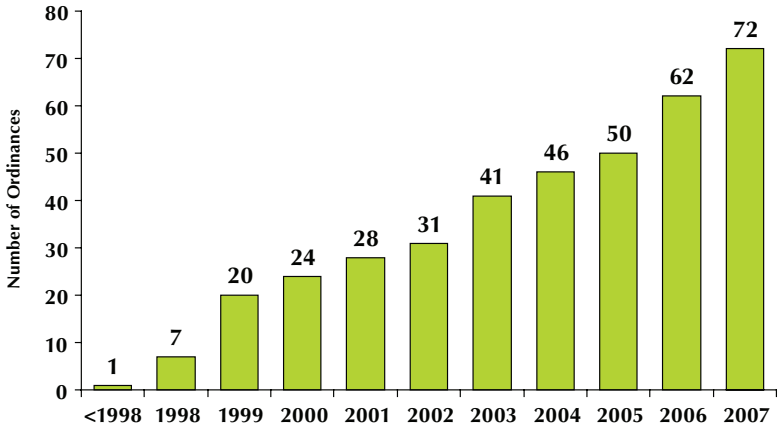
Reducing the Availability of Tobacco

CTCP works to reduce the availability of tobacco by supporting the enforcement of existing laws that prohibit selling tobacco to minors, eliminating free tobacco product sampling, requiring licensure of tobacco retailers, and establishing tobacco-free pharmacies.

Requiring Licensure of Tobacco Retailers

According to local tobacco control ordinance data, the total number of local tobacco retail licensing ordinances has increased by 200 percent between 2000 and 2007 corresponding with the launch of the statewide STORE Campaign in 2002. Over 70 such ordinances are now in place (Figure 6). Progress of local tobacco retail licensing efforts has been slowed due to the statewide California Cigarette & Tobacco Products Licensing Act of 2003. The licensing act was intended to decrease tobacco excise tax evasion, and requires businesses selling cigarettes and other tobacco products to the public to obtain a license in order to distribute tobacco products in California.† The law requires a one time fee of $100 which is insufficient to support the Board of Equalization's (BOE) inspection cost. The present fee structure generates just over $1 million annually, while the cost to administer the program is over $9 million annually.

Figure 6. Cumulative Number of Local Tobacco Retailer Licensing Ordinances, 1998-2007



Note that these are the years in which the ordinance was last amended.
Source: Local Tobacco Control Ordinance Database-California updated July 2008, maintained by American Nonsmokers' Rights Foundation.
Prepared by California Department of Public Health, California Tobacco Control Program, 2008.

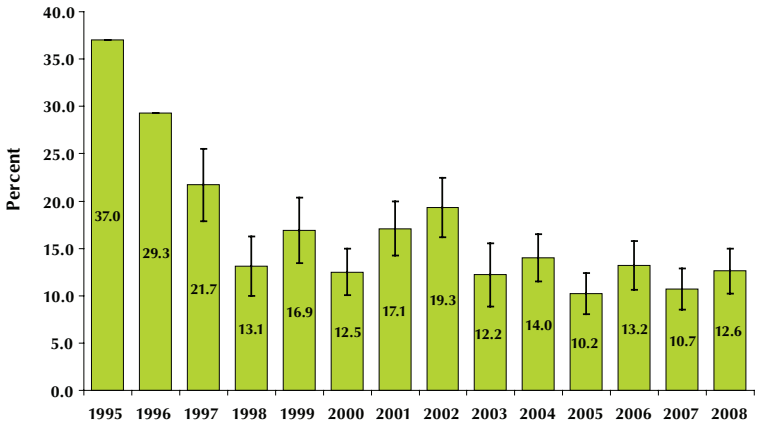
The Center for Tobacco Policy and Organizing (a project of the American Lung Association of California) has defined a strong local tobacco licensing ordinance as an ordinance that includes renewal of an annual license with a fee that will support enforcement efforts (compliance checks), and allows for fines and penalties. The number of strong local Tobacco

* California Student Tobacco Survey (CSTS), 2006, California Department of Public Health.
† California Business & Professions Code Section 22970

Retailer Licensing (TRL) city and county ordinances throughout California has climbed from 13 to 53 between 2006 and 2008.[21]

Strengthened local enforcement efforts and a continually growing number of local licensing ordinances have resulted in tremendous declines in the rate of illegal tobacco sales to minors. Between 1995 and 2007, the illegal sales rate decreased from 37 percent to 10.7 percent, however, it increased to 12.6 percent in 2008 (Figure 7).

Figure 7. Percent of Retailers Selling Tobacco to Youth, 1995-2008

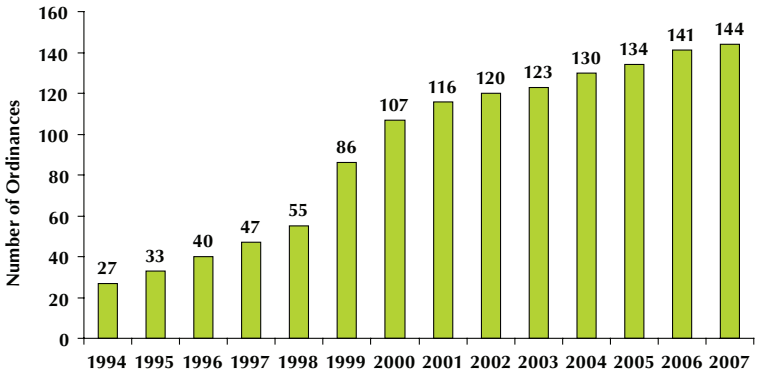


Attempted buy protocol 1995-1996; Actual buy protocol 1997-2008.
Source: Youth Tobacco Purchase Survey, 1995-2008.
Prepared by: California Department of Public Health, California Tobacco Control Program, July 2008.

Supporting Enforcement of Laws That Prohibit Selling Tobacco to Minors

California's statewide tobacco control laws help reduce the availability of tobacco products and paraphernalia to adults and youth. In California, it is illegal to sell tobacco products to individuals under the age of 18* and every business that sells tobacco products is required to post age-of-sale warning signs where tobacco sales take place.† Californians have long been concerned about the TI's marketing practices at the local level, which in turn prompts local ordinances like those which ban self-service tobacco sales.‡ The number of local ordinances passed to ban self-service tobacco sales at the local level has increased five-fold since 1994, which has led to the enactment and expansion of a state law that bans the self-service display of tobacco products (Figure 8).

Figure 8. Cumulative Number of Local Ordinances Passed on Banning Self-service Tobacco Sales, 1994-2007



Note that these are the years in which the ordinance was last amended.
Source: Local Tobacco Control Ordinance Database-California updated July 2008, maintained by American Nonsmokers' Rights Foundation.
Prepared by California Department of Public Health, California Tobacco Control Program, 2008.

Eliminating Free Tobacco Product Sampling

The TI continues to sponsor a large number of events that have significant youth and young adult attendance. Of the events observed that had sponsorship, 51.2 percent (21 out of 41 events) had youth participants and discounted tickets for youth i.e., aged 18 and younger. About 39 percent of these sponsored events had adult-only

* California Penal Code Section 308 (1991) and California Business and Professions code Section 22960 & 22962 [Stop Tobacco Access to Kids Enforcement (STAKE) Act, 1995].
† California Business and Professions Code Section 22950–22960.
‡ California Business and Professions code Section 22960 & 22962 (STAKE Act).

areas that usually used signage to bring in patrons. Thirty-five percent of these adult-only areas used free tobacco samples to attract patrons. However, the Attorney General did not take action against the TI's sampling activities at any of these events. As a result, it can be concluded that even though sampling continues to take place it appears to occur mostly in adult-only areas as specified within MSA regulations.

As the youngest group of legal smokers, 18-24 year olds have been specifically targeted by TI marketing.[22] After the 1998 MSA with the states, tobacco companies increased marketing aimed at college students by sponsoring events at college bars and the distribution of free samples to college students[23] as well as distributing free samples at promotional events at fraternities.[24, 25] Tobacco company documents demonstrate that bar promotions are highly effective at increasing sales by encouraging brand switching, smoking initiation and relapse by quitters.[26]

Although California law and the MSA already prohibit the distribution of free tobacco samples in most public places, there are exceptions for adult-only locations, like bars.[27] Tobacco companies sponsor "bar nights" where they give away free samples of their products in bars. Sampling is also permitted at private events that are open to the public, as long as the free distribution takes place in a separate area that minors cannot access or see inside (e.g., a tobacco company sampling tent at a rodeo or motor racing event). Local governments can provide stricter regulations than state law or the MSA by completely banning tobacco sampling at bar nights and other locations, such as sororities and fraternities.

To reduce the availability of tobacco, California cities and counties are increasingly pushing to limit the free or low cost distribution of tobacco products by the TI, also known as "sampling." On December 4, 2007, the Chico City Council voted 6-1 to add a chapter to the Chico Municipal Code to regulate the non-sale distribution of smokeless tobacco or cigarettes within the boundaries of the city. "Non-sale distribution" was defined in this ordinance as "to give smokeless tobacco or cigarettes to the general public at no cost, or at nominal cost, or to give coupons, coupon offers, or rebate offers for smokeless tobacco or cigarettes to the general public at no cost or at nominal cost." This ordinance effectively prohibits the free distribution of tobacco products at bars, fraternities, sororities, convenience stores and gas stations within city limits.[28]

Establishing Tobacco-Free Pharmacies

The negative health effects of smoking are well-known such as lung cancer, cardiovascular, and respiratory diseases,[15] and quitting often takes multiple attempts. In some pharmacies and drug stores, smokers picking up prescription medications are confronted with cigarettes – often in the same isle.

CTCP encourages local agencies and competitive grantees to work toward the adoption and implementation of legislated and voluntary policies that prohibit the sale of tobacco products by independent and chain pharmacy stores. There are approximately 5,300 licensed pharmacies in California, including independent pharmacies, as well as those located in hospitals, clinics, chain drugstores, discount and warehouse retail outlets and grocery stores.[29] Approximately 57 percent, or over 3,000 California pharmacies continue to sell tobacco products, including the four major chain pharmacies (Longs Drugs, Rite Aid, Sav-On and Walgreens) which represent over half (1,743 or 58 percent) of licensed pharmacies that continue to sell tobacco products in California.

In 2007, almost 75 percent of California smokers planned to quit within the next six months, and over half of smokers took action and made at least one quit attempt in the past year

Currently, seven CTCP-funded projects are working toward the adoption and/or implementation of legislated or voluntary policy that prohibits the sale, advertising and/or promotion of tobacco products by independent and chain pharmacy stores.

Through the combined efforts of the health care community, tobacco control advocates, and the general public, many of California's independent pharmacies have stopped selling tobacco products. In August 2008, the City of San Francisco enacted an ordinance that prohibits pharmacies from selling tobacco products. The ban of tobacco sales in pharmacies, which went into effect October 1, 2008, does not extend to general grocery stores or "Big Box Stores" (single retail establishment occupying an area in excess of 100,000 gross square feet); however, the ordinance makes San Francisco the first city in the United States to ban the sale of cigarettes in pharmacies.[30] In contrast, across California the majority of chain drug stores continue to sell tobacco and most also post tobacco advertising, despite tobacco product sales by pharmacies and drug stores typically make up less than one percent of their total sales.[31] Selling tobacco products sends a misleading message which conflicts with a pharmacy's purpose of promoting health.

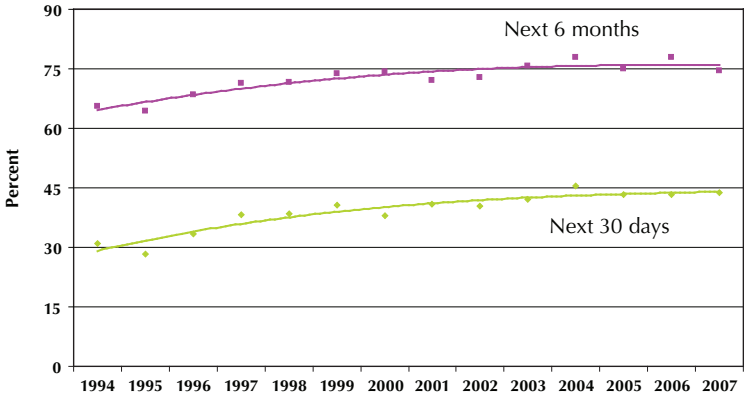
Cessation

In California, more smokers than ever are trying to quit because social norms have shifted away from the acceptability of smoking.[32-34] Successful quitting is a complex and difficult process which, in many individuals, is characterized by repeat quit attempts because tobacco is addictive. CTCP provides support for the operation of the Helpline and for population-based cessation programs.

Quitting cigarette smoking earlier has been shown to reduce one's risk of prematurely dying.[35,36] Research has found that quitting at age 50 could cut the risk of dying by half and if cessation occurs at age 30 or younger, the risk is almost entirely

avoided.[37] Quitting smoking can also increase one's life expectancy. A smoker who quits smoking at age 60, 50, 40, or 30 can gain 3, 6, 9, or 10 more years of life, respectively.[38] Being a current smoker in California does not necessarily reflect a lack of quit intention or translate to actual quitting activities. Over the years, a steadily increasing majority of California smokers have reported intentions to quit in the near future (Figure 9). California smokers have also increasingly reduced their cigarette consumption and have become less addicted,* which is an indicator of future quit attempts.

Figure 9. Proportion of California Smokers Thinking about Quitting (1994-2007)



Source: California Adult Tobacco Survey/Behavioral Risk Factor Surveillance System 1994-2007
Prepared by: California Department of Public Health, California Tobacco Control Program, February, 2008

In 2007, over 50 percent of smokers reported taking action and making at least one quit attempt in the past year. Moreover, smokers themselves have developed positive attitudes reflecting this change, such as those attitudes related to SHS and countering pro-tobacco influences. Data shows that smokers who support or agree with policies to reduce SHS are two times more likely to have made a recent quit attempt or have intentions to quit in the next six months.[39] In 2005, individuals who tried to quit smoking were more likely to succeed if they had a workplace and/or household smoking ban (13 percent and 11 percent) compared to those who had no ban (5 percent).† Research has shown that smokers are more likely to make a quit attempt and be successful if they have a home smoking ban in place.[38, 40] The percentage of current smokers that adopted a home smoking ban increased by two-thirds between 1996 and 2005, from 36 percent to 58 percent, which primes the environment for smokers to quit. The increase in home smoking bans among smokers between 1996 and 2005 is also an indication of the social norm change.

The California Smokers' Helpline

CDPH funds the California smokers' Helpline, a free statewide telephone service (1-800-NO-BUTTS) that has provided assistance to over 434,000 people since its inception in 1992 through July 2007. Helpline services are both culturally and linguistically appropriate, are provided in six languages (English, Spanish,

* California Adult Tobacco Survey and Behavior Risk Factor Surveillance System, 1994-2007, California Department of Public Health. California Tobacco Survey, 1996-2005, California Department of Public Health.
† A successful quitter is defined as a smoker who smoked 12 months prior to the survey being conducted but was not smoking at the time of the interview. California Tobacco Survey, 2005, California Department of Public Health.

Mandarin, Cantonese, Vietnamese, and Korean), and are available for the hearing impaired. There are also specialized services for teens and pregnant women, as well as a line specifically for tobacco chewers. According to the recent report, 25.6 percent of callers to the Helpline showed 12-month abstinence from smoking after multiple counseling, which is significantly higher than the self-help group for the same period of time (18.8 percent).[41]

Back

Front

The Helpline has had great success building partnerships and relationships throughout the tobacco control community, including relationships with physicians and other healthcare practitioners. More referrals come to the Helpline from healthcare providers who are encouraging their patients to give up smoking, and many healthcare providers now endorse the "Ask, Advise, Refer" intervention. This intervention teaches providers about the Ask, Advise, Refer technique, and how referrals for cessation help patients reduce their risk of complications and improve their health. Providers are encouraged to **ask** patients if they smoke, **advise** smokers to quit, and **refer** them to the California Smokers' Helpline for free tobacco cessation counseling with the "Take Charge" Gold Card.

The Helpline's Gold Card is a credit card size card that lists phone numbers for the smoke, chew, and TDD/TTY lines. The Gold Card is a marketing piece that effectively encourages smokers to call for help when ready. The "Do you cAARd?" campaign is a collaborative effort of California Diabetes Educators, the California Diabetes Program and the Helpline as a result of smoking cessation quitline enhancement funds in 2004 by the CDC. CTCP sought to focus on promoting smoking cessation among people with diabetes because 2 million people live with diabetes in California* and smoking is known to exacerbate the harmful effects of diabetes by increasing insulin resistance and worsening diabetes control.[42-44] The campaign includes a toolkit for diabetes educators and other health care providers, an American Association of Diabetes Educators (AADE) accredited continuing education program on diabetes and tobacco cessation, and education opportunities offered statewide by the "Do you cAARd?" Task Force. The goals of the campaign are to increase

*Data from the California Diabetes Prevention and Control Program: diabetes data for California: Prevalence and Risk Factors. California Department of Health Services,1997.

use of telephone-based tobacco cessation services by persons with diabetes and to improve the extent to which health care providers assess the smoking status of persons living with diabetes, advise them to quit, and refer them to the Helpline.

Population-Based Cessation Efforts

Population-based efforts focusing on educating the smoker and providing clinic-based cessation assistance have been augmented by efforts to change community norms, restrict where smoking is allowed, increase the cost of cigarettes, and provide societal-based persistent and inescapable messages to quit, coupled with support for cessation.[45] To encourage tobacco users to quit, CTCP promotes community-wide, comprehensive programs that use multiple channels to engage individuals. Comprehensive evidence-based programs usually include cessation services, policy initiatives such as smoke-free environments, increases in the price of tobacco products, worksite initiatives to increase cessation, and mass media education campaigns.[46] CTCP-funded projects continue to work toward system changes that support population-based cessation services, including: introducing cessation and tobacco user identification programs into large managed health care plans, coordinating with low income clinics providing health care to indigent populations and university/college health centers that serve priority populations, providing healthcare professionals with training to establish systemized patient education and treatment programs in private offices and clinics, and cooperating with the American Cancer Society to sponsor the Great American Smokeout.

Currently, eight CTCP-funded projects are working to promote system changes in their cities, counties, managed care health plans, alcohol, drug, and mental health programs, community-based organizations, coalitions, networks, clinics, and various other social and/or health programs. These projects are advocating the adoption of policies related to the routine assessment of tobacco use, the adoption of screening and referral protocols, the adoption of the U.S. Public Health Service Clinical Practice Guidelines for Treating Tobacco Use and Dependence,[47] and referral to culturally and linguistically appropriate cessation services and/or the Helpline.

Increasing the price of tobacco would directly impact consumption, cessation and initiation, and would also lower overall health care costs in California. Increasing the price that consumers pay for tobacco products reduces the consumption of tobacco by making it less affordable.[48-52] In 1988, Prop 99 increased the tax on a pack of ciga-

rettes by 25 cents, and created an equivalent tax on other tobacco products. In 1993, the legislature increased the cigarette tax by 2 cents per pack to fund breast cancer research and early detection services. In 1998, Prop 10 increased the tax by an additional 50 cent per pack. The passage of Prop 10 brought the state's tobacco tax to its current 87 cents. Despite the tax increases through the late 1990's, California currently ranks 30th among states regarding cigarette tax rate because the state has not increased its tobacco tax for 10 years (see Figure 1; the U.S. average is $1.164 per pack). Furthermore, Californians still support a higher tobacco tax. In 2007, 57.2 percent of California adults supported a cigarette tax increase of at least one dollar per pack, and 78.7 percent supported a tax increase of 25 cents or more per pack.*

There are still 3.6 million adult smokers in California in 2007,† and according to the data on the Smoking-Attributable Mortality, and Morbidity, and Economic cost (SAMMEC) by CDC, over 34,000 deaths were attribted to smoking in California in 2004‡. Researchers estimated the total cost of smoking in California at $15.8 billion in 1999, which reflects direct costs of $8.6 billion and indirect costs of $7.2 billion (due to lost productivity from illness and premature deaths).[53] A $1.50 tobacco tax increase and a funding augmentation for the program would generate at least 275,000 quitters among current smokers and prevent over 100,000 youth from starting. As a long-term result of a $1.50 tax increase, approximately 180,000 deaths due to smoking would be prevented.§

* California Adult Tobacco Survey, 2007, California Department of Public Health.
† Data from the California Adult Tobacco Survey, Behavior Risk Factor Surveillance System, and Department of Finance.
‡ Smoking - Attributable Mortality, and Morbidity and Economic Costs, Center for Disease Control and Prevention.
§ California Tobacco Control Program, unpublished data, 2008

The Results

Differences in expenditures between the TI and CTCP have continued to increase since the 1990s. Despite funding challenges, CTCP has had a great deal of success decreasing smoking prevalence among all Californians (including youth) and decreasing tobacco-related diseases, which indicates the overall effectiveness of the tobacco control program. However, the average price of a pack of cigarettes has stagnated over the last few years and the decline of smoking prevalence appears to have stalled, particularly among youth.[54-56]

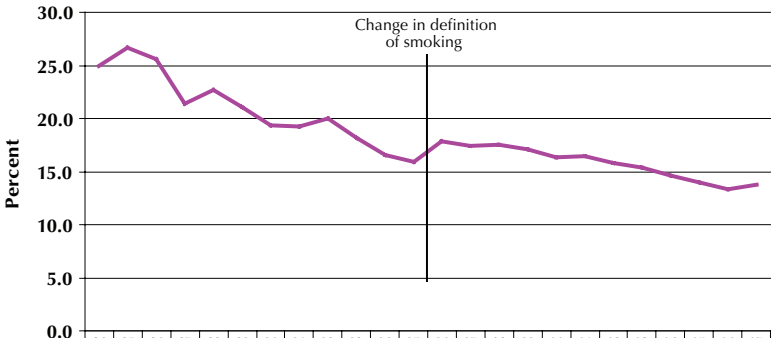
Smoking prevalence has significantly declined from 22.7 percent in 1988 to 13.8 percent in 2007.

California Adult Smoking Trends

Overall smoking prevalence in California has declined steadily over the years. Smoking prevalence declined by 35.0 percent between 1988 and 2007, from 22.7 percent to 13.8 percent respectively (Figure 10). However, the most recent survey results (2007) showed a slight increase of 3.8 percent compared to the 2006 survey.

The decline in prevalence was most dramatic in the early years of the program (1989 to 1994) and the rebound in smoking prevalence seen in 1996 is an artifact of the change in the definition of "current smoker" adopted at that time which included more occasional smokers. In 2006, California had the second lowest cigarette smoking prevalence rates for adults over age 25 of all states, only higher than Utah, according to the National Survey on Drug Use and Health sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA).[57]

Figure 10. Smoking prevalence among California Adults, 1984-2007



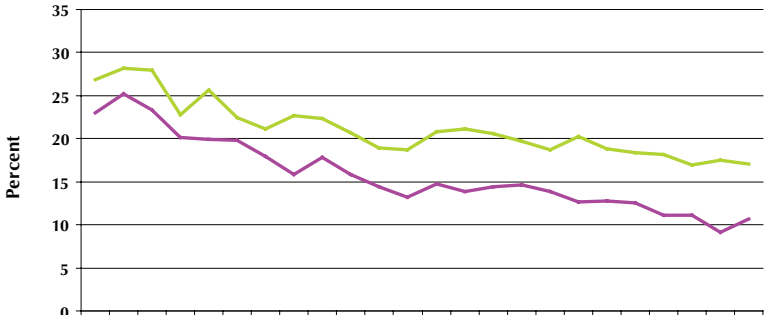
	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	00	01	02	03	04	05	06	07
CA	24.9	26.7	25.6	21.4	22.7	21.1	19.4	19.2	20.0	18.2	16.6	15.9	17.8	17.4	17.5	17.1	16.3	16.4	15.8	15.4	14.6	14.0	13.3	13.8

Source: Behavioral Risk Factor Surveillance System (BRFSS) 1984-1992, BRFSS and California Adult Tobacco Survey data is combined for 1993-2007. The data is weighted to the 2000 California population. Note change of smoking definition in 1996 that included more occasional smokers. Prepared by: California Department of Public Health, California Tobacco Control Program, March 2008.

Gender/Age

California men have consistently had higher smoking prevalence rates compared to women.* Overall, smoking prevalence rates for both males and females have decreased 36.4 percent and 53.5 percent respectively since 1984 (Figure 11). Smoking

Figure 11. Smoking prevalence among California adults by gender, 1984-2007



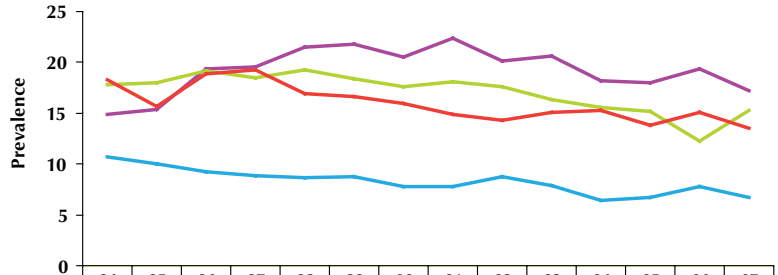
	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	00	01	02	03	04	05	06	07
Male	26.9	28.2	28.0	22.8	25.6	22.5	21.1	22.7	22.3	20.7	18.9	18.7	20.8	21.1	20.6	19.7	18.7	20.2	18.8	18.4	18.2	17.0	17.5	17.1
Female	23.0	25.2	23.3	20.1	19.9	19.8	17.9	15.8	17.8	15.8	14.4	13.2	14.8	13.9	14.4	14.6	13.9	12.7	12.8	12.5	11.1	11.1	9.1	10.7

Source: Behavioral Risk Factor Surveillance System (BRFSS) 1984-1992, BRFSS and California Adult Tobacco Survey data is combined for 1993-2007. The data is weighted to the 2000 California population. Note change of smoking definition in 1996 that included more occasional smokers. Prepared by: California Department of Public Health, California Tobacco Control Program, March 2008.

* California Adult Tobacco Survey and Behavior Risk Factor Surveillance System, 1994-2007, California Department of Public Health.

prevalence rates for all age groups have declined steadily since 1998 (Figure 12). Young adults aged 18-24 remain the group with the highest smoking prevalence rate. However, smoking prevalence for the 18-24 year-old age group dropped by 23 percent in 2007 from its peak in 2001. Adults age 65 and older continued to show the lowest smoking prevalence, below 10 percent since 1995.

Figure 12. Smoking Prevalence among California Adults by Age Group, 1994-2007



	94	95	96	97	98	99	00	01	02	03	04	05	06	07
18-24	14.9	15.4	19.4	19.6	21.5	21.8	20.5	22.4	20.1	20.6	18.2	18.0	19.4	17.2
25-44	17.8	18.0	19.2	18.5	19.3	18.4	17.6	18.1	17.6	16.3	15.6	15.2	12.3	15.3
45-64	18.3	15.7	18.9	19.3	16.9	16.6	16.0	14.9	14.3	15.1	15.3	13.8	15.1	13.5
65+	10.7	10.0	9.2	8.9	8.7	8.8	7.8	7.8	8.8	7.9	6.4	6.7	7.8	6.7

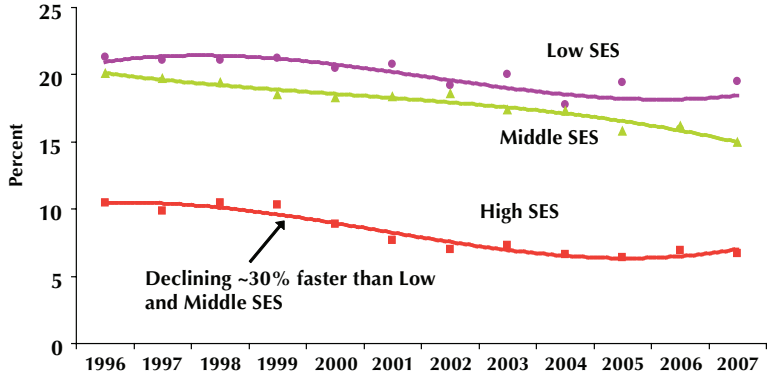
Source: Behavioral Risk Factor Surveillance System (BRFSS) 1984-1992, BRFSS and California Adult Tobacco Survey data is combined for 1993-2007. The data is weighted to the 2000 California population. Note change of smoking definition in 1996 that included more occasional smokers. Prepared by: California Department of Public Health, California Tobacco Control Program, March 2008.

Priority Populations

In 2005, African American males had a higher smoking prevalence rate (21.0 percent) compared to their counterparts in all other major race/ethnicity groups, which were between 16.0 and 16.7 percent. African American and non-Hispanic white females had significantly higher smoking prevalence rates (17.1 and 13.1 percent, respectively) compared to Hispanic (6.8 percent) and Asian/Pacific Islander (6.5 percent) females.[58]

Previously, CTCP funded five studies from 2002-2004 to collect statewide tobacco use information among active-duty military personnel, Asian Indian, Chinese, Korean, and lesbian, gay, bisexual, and transgender (LGBT) populations in California. Active-duty military personnel stationed in California demonstrated a smoking prevalence rate of 21.6 percent, while the highest smoking prevalence, 30.4 percent, was observed in the LGBT community. Korean men had a smoking prevalence rate of 27.9 percent while Chinese and Asian Indian smoking prevalence rates were 7.7 percent and 5.5 percent respectively.[59,60]

Figure 13. Smoking prevalence among California adults by SES, 1996-2007



Source: Behavioral Risk Factor Surveillance System and California Adult Tobacco Survey data is combined for 1993-2005. The data is weighted to the 2000 California population. Note change of smoking definition in 1996 that included more occasional smokers. Low SES is defined as a household income of less than $25,000 and highest educational status is a high school graduate. High SES is defined as a household income of more than $50,00 and the educational is college undergraduate degree or more. Prepared by: California Department of Public Health, California Tobacco Control Program, February 2008.

High smoking prevalence rates among the low socioeconomic status (SES) population are an additional challenge faced in California. Since 1996, smoking prevalence among high SES groups has been relatively low (below 10.0 percent) whereas the prevalence rates among the low and middle SES groups have both remained above 15 percent and have never dropped below 10 percent. Data from the 2007 survey showed that smoking is more prevalent in low SES groups (19.5 percent) compared to middle (15.0 percent) and high SES (6.7 percent) groups (Figure 13). More importantly, low SES as a general group can encompass other

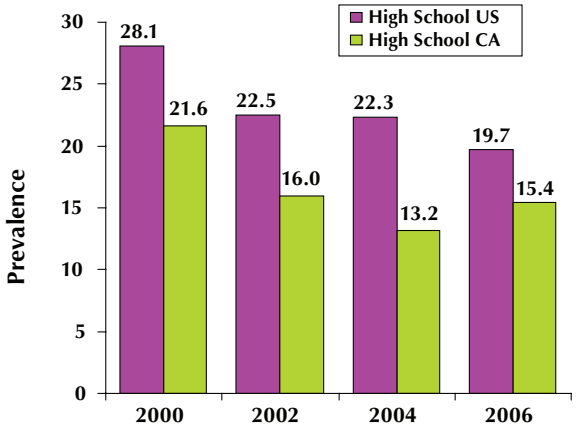
populations, for example, low income Californians can include some minority groups demonstrating that these diverse sub-populations in race/ethnicity or SES are not mutually exclusive. Implementing effective tobacco control programs for the low SES population can be difficult and multi-faceted. It is important to recognize how the TI aggressively targets and markets products to these segments of California's population and the consequential social and health issues faced by low SES populations.

2007 survey showed that smoking is more prevalent in low SES groups (19.5 percent) compared to middle (15.0 percent) and high SES (6.7 percent) groups

California Youth (High School Students) Smoking Trends

Smoking prevalence rates among high school students (9th-12th grade) have declined in California, although, in the most recent survey year (2006) smoking prevalence rose by 16.7 percent compared to 2004 (Figure 14). According to the National Youth Tobacco Survey, smoking prevalence rates for high school students nationwide have steadily decreased. However, California youth still had a significantly lower smoking prevalence compared to the rest of the United States in 2006. Additionally, smoking prevalence rates for youth age 12-17 in California were the second lowest in the nation (7.82 percent) after Hawaii (7.13 percent) according to the SAMHSA National Survey on Drug Use and Health.[57] Causes for this increase in youth smoking prevalence are uncertain, but the increase may have been due in part to low cigarette prices, which can impact youth smoking, or less tobacco control media exposure among youth.[61]

Figure 14. 30-day smoking prevalence for California and U.S. high school (9th-12th grade) students, 2000-2006



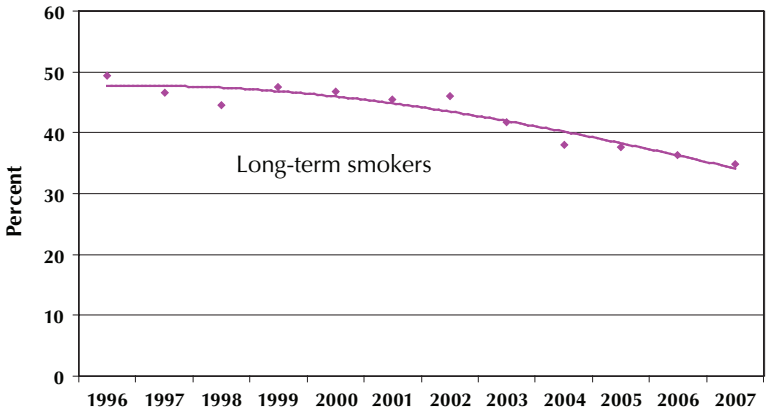
Source: The U.S. data is from the National Youth Tobacco Survey collected by the American Legacy Foundation, which used passive parental consent. The 2002, 2004 and 2006 data is from the California Student Tobacco Survey. The 2002 and 2004 data collection used active parental consent while the 2006 used a mixed parental consent procedure.
Prepared by: California Department of Public Health, California Tobacco Control Program, July 2007.

California Smokers Are Smoking Less

Reducing the number of cigarettes smoked to fewer than 15 cigarettes per day and/or making significant quit attempts have proved to be important strategies in advancing toward successful quitting.[62] Also, smokers who were able to decrease the number of cigarettes smoked per day by at least 25 percent were more likely to quit later.[63] Individuals who smoke fewer than 15 cigarettes per day are considered "light smokers." In 1996, 58.2 percent of current smokers consumed fewer than 15 cigarettes every day. In 2007, the proportion of light smokers grew to 72.3 percent. Similarly, 35.9 percent of smokers did not smoke every day in 2007, an increase from 27.4 percent in 1996.* A similar, if not more significant, trend can be seen for the level of addiction when "smoking the first cigarette within 30 minute after waking" is used as the indicator for addiction level. In 1996, 49.3 percent of smokers who smoked 20 years and more had their first cigarette after

* California Adult Tobacco Survey and Behavior Risk Factor Surveillance System, 1996-2007, California Department of Public Health

Figure 15. Proportion of Smokers Having 1st Cigarettes within 30 Minutes after Waking-up



Source: California Adult Tobacco Survey, 1996-2007
Prepared by: California Department of Public Health, California Tobacco Control Program, February, 2008

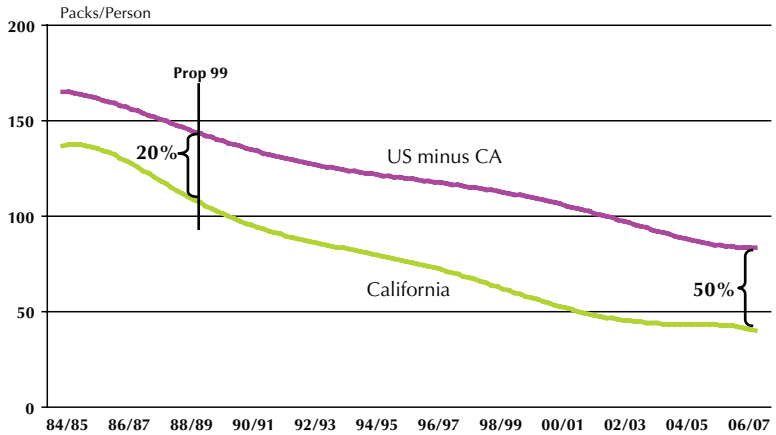
waking up; and only 34.9 percent of smokers did so in 2007 (Figure 15).

From FY 1989-1990 to FY 2006-2007, per capita consumption declined by 60.8 percent in California while the entire United States showed a decrease by 41.0 percent during this same time period (Figure 16). Presently, Californian smokers consume nearly half (40 packs) the number of cigarettes as smokers in the rest of the U.S. (92 packs). The decline in the number of smokers and average number of cigarettes smoked per day, as well as the increase in the proportion of California smokers who are occasional smokers, are reflected in the downward trend in per capita cigarette consumption. In fact, per capita cigarette consumption in the state of California was one of the lowest in the nation in 2006.[64]

From fiscal year 1989-1990 to fiscal year 2006-2007, per capita consumption declined by 60.8 percent in California while the entire U.S. showed a decrease by 41.0 percent.

In 2007, three quarters of California smokers reported (Figure 9) that they were planning to quit within the next six months (74.6 percent) and over 40 percent of California smokers planned to quit within the next month (43.9 percent).* The percentage of smokers who report that they are thinking about quitting within the next 30 days has increased since 1995. Similarly, the percent-age of those who are thinking about quitting within the next six months has also increased, although both measures have remained stable since 2002. However, percentage of smokers who made at least one quit attempt in the last year has been decreasing from 60.2 in 1999 to 56.0 in 2005.†

Figure 16. California and U.S. Adult Per Capita Cigarette Pack Consumption, 1984/1985-2006/2007



Source: California State Board of Equalization (packs sold) and California Department of Finance (population). U.S Census, Tax Burden on Tobacco, and USDA. Note that data is by fiscal year (July 1-June 30). Prepared by: California Department of Health Services, California Tobacco Control Program, November 2007.

* California Adult Tobacco Survey and Behavior Risk Factor Surveillance System, 1993-2007, California Department of Public Health.
† California Tobacco Survey, 1996-2005, California Department of Public Health.

CTCP Reduces Tobacco-Related Diseases and Deaths

The ultimate goal of any tobacco control program is to reduce tobacco-related diseases and deaths. Research has shown the benefits of quitting smoking on various health outcomes including heart disease and lung cancer[37], and in California, continued decreases in death from heart diseases and incidence of lung cancer have been observed.[54,55]

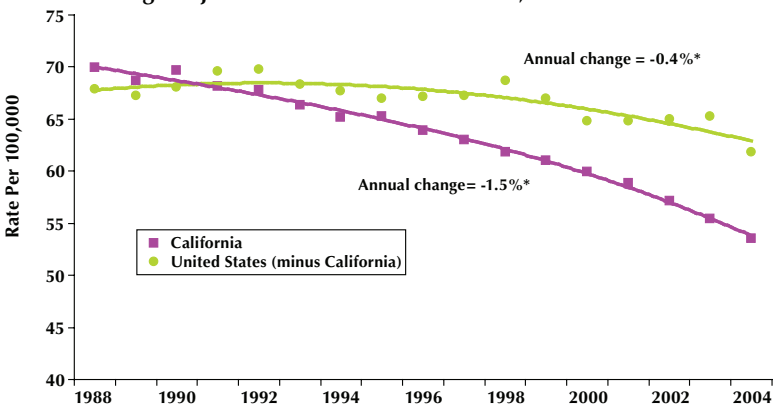
From 1988-2004, lung and bronchus cancer rates in California declined at 3.8 times the rate of decline in the rest of the U.S.

From 1988-2004, lung and bronchus cancer rates in California declined at 3.8 times the rate of decline seen in the rest of the U.S. (Figure 17). Researchers have associated these declines with the efforts of CTCP.[20] Greater declines in smoking-related morbidity and mortality are likely to be seen in the future as tobacco control efforts strengthen and increase.

One research study evaluated the effect of the CTCP on personal health care expenditure between 1989 (the year of the program's inception) and 2004. It showed that $86 billion was saved in health care costs during this period, which also represents 50 times the rate of return on the expense of CTCP, $1.8 billion in 2004 dollars for the same time.[65] Additionally, using a simulation model, researchers investigated how many lives were saved by CTCP program efforts; they estimated that over 50,000 lives would be saved as a result of tobacco control policies such as taxes, the media campaign, clean air laws, and the amount of youth access enforcement in California over the period of 1988-2010.[66]

Research showed that $86 billion was saved in health care costs during 1989-2004, which also represents 50 times the rate of return on the expense of CTCP, $1.8 billion in 2004 dollars for the same time.[65]

Figure 17. Lung and Bronchus Age-adjusted Cancer Incidence Rates, 1988-2004



Rates are per 100,000 and age-adjusted to the 2000 U.S. standard (19 age groups).
* The annual percent change is significantly different from zero ($p<0.05$).
Source: Cancer Surveillance Section. Prepared by: California Department of Public Health, California Tobacco Control Program, 2007.

The Future: New Challenges

Over the last 20 years, adult smoking prevalence in California has decreased by 35 percent, and lung and bronchus cancer incidence rates continue to decline nearly four times faster compared to the rest of the United States. Additionally, many new ordinances and policies have been passed to protect Californians from SHS exposure, and smoking prevalence rates for adults and youth in California are still among the lowest in the nation. Evidence is clear that the CTCP protects health, saves lives and reduces costs. Increasing the price of tobacco in 1988 and investing in new policies and laws, research, local programs, cessation services, public awareness campaigns and restrictions on the TI has led to significant reductions in tobacco related diseases and deaths in California.

There are still approximately four million smokers in California (3.6 million adults and 300,000 youth), which is a number larger than the entire population of the state of Oregon.

Despite continued success in California, CTCP continues to face new challenges including inflation, population changes, and declines in the purchasing power of tobacco control dollars. Additionally, from 2003 to 2007, the relative price of tobacco has decreased by approximately 71 cents. According to the most recent California statewide survey, smoking prevalence rates for adults and youth increased slightly, and the goals set by the Tobacco Education and Research Oversight Committee (TEROC) – 10 percent smoking prevalence for adults and eight percent smoking prevalence for high-school-age youth by the end of 2008 – are still unmet. Also, many Californians continue to be exposed to toxic SHS in multi-unit housing, Indian casinos, public outdoor spaces, and at public events.

Encouragingly, the challenges faced in California have concrete solutions, characterized by a reinvestment in tobacco control. In order to ensure the fiscal and programmatic strength needed to protect Californians against the dangerous and addictive effects of tobacco use and to achieve a tobacco-free state, an increase in the price of tobacco and tobacco control spending in California is essential. Without proper attention and support, the gains made by CTCP will diminish. An increased investment in CTCP will have a catalytic effect, reducing the health burden and costs of tobacco-related diseases and deaths, and moving California forward to be the first tobacco-free state in the nation. CTCP will continue to focus on changing the social norms surrounding tobacco use and supporting collaborative efforts with local health agencies and other non-governmental organizations that work hard to achieve a tobacco-free future for California. A renewed investment in California tobacco control will allow us to protect the progress that has been made, regain momentum, and realize the vision of a tobacco-free California.

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